IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 26, 2007

Linda Miller, Administrator
Rosetta Assisted Living-Pendlebury
1970 East 17th Street #103
Idaho Falls, ID 83404

License #: RC-692

Dear Ms. Miller:

On September 19, 2007, a follow-up/revisit, state licensure survey was conducted at Rosetta Assisted Living - Pendlebury. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Karen McDannel, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

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October 2, 2007 **CERTIFIED MAIL #: 7003 0500 0003 1967 0704**

Linda Miller, Administrator
Rosetta Assisted Living-Pendlebury
1970 East 17th Street #103
Idaho Falls, ID 83404

Dear Ms. Miller:

On **September 19, 2007,** a second follow-up/revisit, state licensure survey was conducted by our staff at Rosetta Assisted Living - Pendlebury. As a result of the survey, core issue deficiencies were cited. Enclosed is a Statement of Deficiencies.

Due to the continued failure of the facility to correct this core issue deficiency, in accordance with IDAPA 16.03.22.910.02. the following enforcement actions are imposed. These enforcement actions include but may not be limited to the following:

1. **A consultant with a background in residential care and an Idaho RN license will be obtained and paid for by the facility and approved by the Department. This consultant may not also be employed by the facility as a regular employee. The consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications and a copy of their license will be submitted to the Department for approval no later than October 12, 2007;**

2. **The Department approved consultant will submit a weekly written report to the Department commencing on October 19, *2007* and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Non-Core Issues Punch Lists as well as progress on correction of the core issues identified on The Statement of Deficiencies.**

3. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return any license certificates, currently held by the facility.**

4. **Ban on all new admissions. Readmission from the hospital will be considered after consultation between the facility, the consultant and the department. The ban on new admissions will remain in effect until the department has determined that the facility has**

achieved full compliance with the requirements or the department determines it has received sufficient written evidence and statements from the outside consultants that the facility is in compliance. The facility will then be able to admit new residents in coordination with the consultant.

5. When the consultant and the administrator agree the facility is in full compliance, they will submit the completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) to this office, and a follow up survey will be conducted. To avoid termination of your license, full compliance must be achieved on or before November 5, 2007.

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 15, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 14, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 14, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the Punch List, a copy of which was reviewed and left with you during the exit conference. The completed Punch List form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **October 19, 2007**.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/ sc
Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R692	A. BUILDING _____ B. WING _____	R 09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - PENDLEBURY	875 S PENDLEBURY BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	Initial Comments The following deficiencies were cited during the second follow-up survey conducted at your residential care/assisted living facility on 9/19/07. The surveyors conducting your survey were: Karen McDannel, RN Team Coordinator Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor Definitions: ADL = Activities of Daily Living BMP = Behavior Management Plan CM = Centimeters CNA = Certified Nursing Assistant NSA = Negotiated Service Agreement O2 = Oxygen RN = Registered Nurse UAI = Uniform Assessment Instrument	{R 000}		
{R 008}	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to protect resident rights by not providing a safe and	{R 008}		

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{R 008}	Continued From page 1 sanitary environment. This failure had the potential to affect 100% of the residents in the facility. The facility failed to develop NSAs to describe how the residents needs would be met for 3 of the 6 sampled residents (residents # 2, # 4 and #5). The facility also failed to implement an NSA in regards to Resident #1's mobility/ambulation needs. Additionally, the facility failed to update an NSA to direct staff in safe transfers for Resident #3 after a change in condition. Furthermore, the facility failed to provide immediate emergency services or medical intervention for Resident #3 and Resident #6 after they sustained a significant change in health status. The findings include: I. Resident Rights Each resident has the right to a safe and sanitary environment. 1. Review of the facility's "Infection Control" policy on 9/19/07 documented, "It is our responsibility and goal to keep the environment free from disease causing pathogens. Gloves will be worn by anyone touching blood, body fluids, mucous membranes, or non-intact skin. Gloves will also be used when handling items and surfaces soiled with blood, body fluids, and for performing any vascular access procedure. Gloves will be changed after contact with each resident. Good handwashing is to be used." On 9/18/07 at 7:11 a.m., a caregiver was observed wearing gloves and providing hands on assistance to residents while bringing them to the dining room table. She left the dining area to enter the kitchen to retrieve dishes wearing the same gloves and did not change gloves after leaving the kitchen.	{R 008}		

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{R 008}	Continued From page 2 On 9/18/07 at 7:40 a.m., a caregiver was observed fixing breakfast wearing gloves. She left the kitchen to go into a resident's room with the same gloves on. She returned to the dining room, closed the blinds and then returned to the kitchen to prepare breakfast without removing the gloves. On 9/18/07 at 8:00 a.m., a caregiver was observed serving breakfast wearing gloves. She walked to a resident to adjust his wheelchair and reposition him, then walked back to the kitchen to grab an egg muffin with her gloved hand. She then brought the egg muffin to another resident sitting in the dining room. On 9/18/07 at 8:25 a.m., a caregiver was observed providing cares to a resident then returned to the kitchen and changed gloves, but did not wash her hands. On 9/18/07 at 8:30 a.m., the caregiver stated that she had only been working for a couple weeks and had only received four hours of orientation. On 9/19/07 at 12:05 p.m., the administrator confirmed that new staff had not been trained on proper glove usage and infection control procedures. 2. The facility's "Cleaning" policy (not dated) documented "the goal is to maintain a clean, sanitary, and orderly environment. Cleaning service will be done on a routine basis depending on the individual facility needs." On 9/18/07 from 7:00 a.m. until 4:30 p.m., observations were made about the cleanliness of the facility. It was observed that in the living room large stains were present in the worn carpet. The	{R 008}		

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{R 008}	Continued From page 3 seams of the carpet were frayed and visible. There was a musty odor present. The baseboards of the living room and hallways had layer of dust present and the wood was chipped. A vent in the front room was covered in dust. In the hallways, the carpet was also stained. Torn wallpaper was observed in several residents' rooms. Walls were observed to be in need of repair and painting throughout the facility. In room 2, a pungent urine odor was noted upon entering the room and bathroom. The toilet bowel contained a yellowish-brown film and had fecal smears. In room 3, a yellowish-brown sediment was observed in the toilet. A urine odor was present and a urinal sat on the bathroom sink. In room 5, the carpet was observed as stained and greasy. A musty odor was present. In room 6, a musty urine smell was observed upon entering. The carpet was stained and worn. In room 7, The wallpaper was observed to be torn. The toilet bowel had a white film. A shaving kit with sharp fingernail scissors and a razor was left on the countertop by the sink. In room 11, a strong urine odor was present. On 9/18/07 at 3:37 p.m., the administrator confirmed the walls needed painted and only a small portion had been completed. She also confirmed the carpet had been in need of replacement for several years now and had been on order since July of 2007. She also verified the baseboards and walls throughout the facility were in need of repair.	{R 008}		

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{R 008}	Continued From page 4 The facility failed to maintain a safe and sanitary environment based upon their policies and procedures. Therefore, residents' rights were not protected. II. NSAs A. Development of NSA 1. Resident #4 was admitted to the facility on 3/30/07, with diagnoses which included Dementia, type-two diabetes and chronic abdominal pain. The NSA updated on 9/13/07, included a section titled, "Behavior Management/Interpersonal." This section was blank, and a "No" was check-marked for "Behavorial Plan in Use." Hospice was check-marked under "General Medical Needs/Conditions." On 9/18/07 at 7:55 a.m., Resident #4 was observed yelling, "Go away," and waving her hand at a random resident as he walked by. On 9/19/07 at 9:00 a.m., a caregiver stated, "She gets really agitated if her husband asks her for stuff. We try to offer her activities when she does that. She may be in good spirits one moment and later she is agitated." A "Nursing Clinical Note" dated 4/4/07, documented, "Pt. is very forgetful and confused. She attempts to help her husband out of bed and he keeps falling." A "Hospice CNA visit Note," dated 5/29/07, documented, "Resident combative again today."	{R 008}		

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{R 008}	Continued From page 5 A "Home Health and Hospice Nursing" note dated 7/23/07, documented, "Pt. is attempting to take care of husband. Pt. gets very angry with other residents if they come close to husband. Staff reports that she has been yelling at husband." A "Hospice visit note" dated 7/31/07 documented, "Resident very combative today, swearing at staff and myself consistently. Staff says she was even hitting husband and yelling all night stomping her feet and acting like a child this morning." A "Social Work Progress Note" dated 8/6/07 documented, "Patient is angry, often aggressive in her interactions with her spouse." An incident report dated 8/13/07, documented that staff had found Resident #4's husband on the bathroom floor after she had yelled out for help when attempting to assist him independently. A "Hospice CNA visit Note," dated 8/21/07 documented, "Resident very nasty to husband today." An Incident report dated 9/1/07 documented, "[Resident #4] was sitting in the chair and [a resident] was walking by her room and she started to run after him and started hitting him in the sides and on his face screaming at him....She has been hitting all day." A "Social Work Progress Note" dated 9/3/07 documented, "Assisted Living staff report that she has recently begun to hit other residents. Based on staff reports she has been hitting her spouse for no apparent reason for some time." An Incident Report dated 9/13/07, documented	{R 008}		

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{R 008}	Continued From page 6 Resident #4 had hit a resident on the shoulder and hand after the resident walked by her wheelchair. A progress note, undated, from the resident's hospice R.N. documented, "Staff reports resident has increased agitation. She is yelling at spouse and hitting him." A "Behavior Care Plan" dated 9/4/07, addressed Resident #4's aggressive behavior towards another specific resident and included interventions, but did not include a plan to address Resident #4's aggressive behavior towards her husband. Further, a behavior tracking system was not in place to track behaviors and monitor interventions. The facility failed to develop an NSA to guide staff in the management of Resident #4's behaviors towards other residents and towards the resident's spouse, in order to ensure a safe environment for all residents. Further, the NSA was not developed to describe the services and cares provided through hospice. 2. Resident #5 was admitted to the facility on 7/24/07, with diagnoses which included hypertension and diabetes. Resident #5's NSA dated 8/7/07, documented the resident required supervision and /or cueing to be reminded to take medications. The NSA did not document if the resident required the use of oxygen or guide caregivers on how to assist the resident with her oxygen needs. A nursing assessment, completed by the facility RN, dated 8/24/07, documented Resident #5 used oxygen, but it did not document the liters of	{R 008}		

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{R 008}	Continued From page 7 oxygen to be used or how often the resident needed to use the oxygen. A physician's order dated 8/24/07, documented the resident was to receive: *O2 2 Liters per nasal passage. The order did not give parameters of how often the resident should use the oxygen or give guidance to the facility caregivers on how to assist the resident with her oxygen use. On 9/19/07 at 8:26 a.m., the resident was observed in her room without wearing her oxygen. On 9/19/07 at 3:10 p.m., the resident was observed sitting in a recliner in her room without wearing her oxygen and the oxygen machine was turned off. On 9/18/07 at 3:06 p.m., the resident stated that she had received the oxygen when she moved into the facility, but had not used it. On 9/18/07 at 2:28 p.m., the assistant administrator stated the O2 was to be used as needed, but could not explain why the NSA or physician's orders did not guide caregivers on how and when the resident should be assisted with her O2 use. On 9/18/07 at 3:31 p.m., a caregiver stated the resident would use and request the oxygen as needed, especially after walking around the facility and having some shortness of breath. On 9/18/07 at 3:33 p.m., a second caregiver stated when the resident came from the hospital	{R 008}		

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{R 008}	Continued From page 8 in August she used the O2 for 3 to 4 days and used it occasionally when she ambulated around the facility. She also stated the resident had used the O2 in August, but had not used the O2 since the beginning of September. The NSA was not developed to reflect Resident #5's current needs regarding how often the resident was to be assisted with the use of her oxygen. 3. Resident #2 was admitted to the facility on 3/30/07, with diagnoses which included failure to thrive and congestive heart failure. The resident's record contained an NSA dated 3/30/07, which documented the resident had contract services with hospice. The NSA did not contain documented evidence of what services were being provided by the hospice agency. Additionally, it documented the resident needed moderate assistance with personal hygiene and could complete most of his own personal hygiene but did need assistance occasionally due to weakness. The NSA did not describe what assistance the resident needed for bathing under the personal hygiene section Review of the "Assisted living facility agreement list of services and items to be provided by the hospice for patients in assisted living facilities" documented the RN would visit the facility 2 times a week, Monday thru Friday, the CNA would visit the facility 5 days a week, not to miss more than 1 day in between visits. Additionally, it stated the CNA would provide bed baths and monitor the resident's skin condition. The facility's progress notes documented on 9/13/07, "discussed with hospice RN, getting	{R 008}		

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{R 008}	Continued From page 9 patient up to shower, she prefers he is just bed bathed per hospice staff." On 9/18/07 at 9:43 a.m., the assistant administrator stated the resident received a bed bath or shower 4 times a week and hospice provided all of the resident's bathing needs. On 9/18/07 at 9:50 a.m., a caregiver stated hospice gave the resident bed baths, but if the hospice aide was not able to come into the facility, the caregivers would assist the resident with bathing. On 9/18/07 at 2:24 p.m., the hospice aide stated she had visited the facility 5 days a week and never missed 2 days in a row. She stated she assisted the resident with bed baths and ADLs when she visited the facility. The NSA did not describe the role of hospice and what cares hospice would provide and what cares the facility would provide, including bathing, so that coordination of care would be clear. B. NSA IMPLEMENTATION 1. Resident #1 was admitted on 7/29/04, with diagnosis including Dementia, Parkinson's and Psychosis. Mobility: Resident #1's NSA, dated 8/15/07, documented the resident required moderate assistance with mobility and "Staff to encourage use of walker. Shuffles when uses walker-slow gait." On 9/18/07 at 7:30 a.m., Resident #1 was observed walking from his room to the living	{R 008}		

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{R 008}	Continued From page 10 room with a shuffling gait, with his sweat pants falling down. His walker was turned sideways and he scooted it with one hand as he walked to a chair and sat down, while holding his pants up with his other hand. His slippers were observed to be too large for his feet, nearly falling off as he walked to chair to sit down. He stood up from the chair, pulled his pants down and sat down again. A caregiver walked towards him and told him that it was time to change his clothes. He was observed standing back up and scooting his walker sideways again to his room. The caregiver was not observed instructing resident on proper use of walker, as she walked off into his room while he shuffled behind her. On 9/18/07 at 7:52 a.m., Resident #1 was observed walking without his walker to his room and back. Staff were not observed to reminded resident to use walker. A fall risk assessment dated 8/23/07, indicated Resident #1 had a score of 16 points, with 10 points or more indicating a high risk for falls. On 9/18/07, when asked about Resident #1's walker usage, a caregiver stated, "He always walks with his walker sideways." The facility failed to implement Resident #1's NSA in regards to mobility needs; reminders to use walker appropriately were not observed, nor had staff addressed the resident's need for proper fitting footwear despite the resident's high risk for falls. Toileting/hygiene : Resident #1's NSA dated 8/15/07, documented under toileting, "Needs physical assistance with	{R 008}		

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	13R692	A. BUILDING _____ B. WING _____	R 09/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - PENDLEBURY	875 S PENDLEBURY BLACKFOOT, ID 83221

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{R 008}	Continued From page 11 part of the task such as wiping, cleansing.....wears attends occasionally." Under the Personal Hygiene, the NSA documented, "Staff to provide all hygiene needs. Resident is unable to do at this time and get clean." Under "General Medical Needs/Conditions" Hospice was check-marked, but services provided were not specified. On 9/18/07 at 2:50 p.m., a caregiver stated that Resident #1 was independent with toileting and only needed occasional reminders to toilet. The caregiver stated, " I have never showered him as hospice does all showers."A second caregiver in the room at this time confirmed that Resident #1 was not assisted with toileting nor checked to ensure cleanliness nor were showers given from staff. On 9/18/07 at 3:00 p.m., the hospice R.N. stated, "He believes he can toilet himself, but he is incontinent and dribbles. He needs reinforcement to wear attends. His odor can sometimes be rank." The Facility failed to implement the NSA in regards to Resident #1's toileting and hygiene needs as the resident was not assisted with toileting in order to ensure proper pericare. Further, the NSA did not describe the Hospice bathing cares provided to the resident in order to ensure that bathing needs were being implemented. C. UPDATING NSAs 1. Resident #3 was admitted to the facility on 8/28/06, with diagnoses which included Alzheimer's dementia.	{R 008}		

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{R 008}	Continued From page 12 The resident's NSA updated on 9/07/07, documented the resident used a wheelchair for mobility, could assist with own transfers and positioning but needed total assist of 1 caregiver. Additionally, the NSA documented the resident needed stand by assistance for mobility. The NSA also documented that the resident had contract services with hospice, but specific cares provided were not specified. On 9/18/07 at 9:30 a.m., Resident #3 was observed sitting in a recliner near the dining room. Caregiver (A) was observed attempting to transfer the resident from the recliner to her wheelchair. The caregiver placed a gait belt around the resident's waist and attempted to transfer the resident. After trying for 5 minutes, she went to get help from caregiver (B). Both caregivers struggled to get the resident up from the recliner and into her wheelchair. During the transfer the resident stated, "Ough, Ough Ough". On 9/18/07 at 9:45 a.m., the facility nurse stated that Resident #3 had a change in mobility and now required a two person assist for transfers. She further stated she had not trained staff on transferring the resident with the assistance of 2 caregivers and the use of the gait belt. On 9/18/07 at 10:14 a.m., the hospice physical therapist stated, she had not taught gait belt training to staff, and confirmed Resident #3 required a two person transfer for safety and comfort due to a change in condition. The facility nurse stated at this time that gait belt training would occur in two weeks. On 9/18/07 at 3:10 p.m., four caregivers stated they had not received gait belt training but had been using the gait belt after observing the	{R 008}		

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{R 008}	Continued From page 13 hospice CNA using the gait belt to transfer Resident #3. They were also unclear on what hospice services were being provided to the resident. The NSA was not updated to include a two person transfer or the use of a gait belt to guide the caregivers to safely and comfortably transfer the resident. Further, the NSA was not specific in describing Hospice services so coordination of care could be provided. III. Emergency Intervention: 1. Resident #3 was admitted to the facility on 8/28/06, with diagnoses which included Alzheimer's dementia. The NSA, updated on 9/13/07, documented the resident required extensive assistance with toileting, was incontinent of bowel and bladder and wore incontinent briefs. Further, it directed staff to encourage independence with toileting. Additionally, it documented the resident used a wheelchair for mobility, could assist with own transfers and positioning but needed total assist of 1 caregiver. Review of the facility's Incident Report on 9/3/07, documented the following: "Resident #3 fell on floor on 9/3/07 at 7:45 p.m., when she was trying to get up by self. When staff went in resident was on floor sitting in an up position." The incident report documented the evening shift caregiver did a complete check on her body. The caregiver called the house manager to report the fall. The house manager arrived and helped the resident back to bed. The hospice nurse was notified of the fall via phone;	{R 008}		

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{R 008}	Continued From page 14 however, the facility nurse was not notified, nor was an assessment done by a nurse nor were emergency services phoned. Further, the administrator's investigation revealed the resident had fallen after being left unattended while toileting. The resident had gotten up from the toilet and walked from the bathroom into her bedroom and fell from a standing position." The facility's Progress Notes dated 9/4/07, documented that resident had a non-injury fall on 9/3/07, when she got off of the toilet by herself and tried to walk. "Staff will provide stand by assistance when resident uses toilet." The facility's MAR documented Resident #3 had received pain medication on 9/3/07 at 8:00 p.m. for pain. On 9/18/07 at 2:30 p.m., the house manager confirmed that Resident #3 had not complained of pain upon putting her to bed, but she gave the resident pain medication directly after the fall in case she experienced pain. She also confirmed the facility nurse nor the hospice nurse gave direction to administer the pain medication. Additionally, she stated pain medication was given to the resident three consecutive days after the fall. The hospice nurse documented on a hospice Progress Note dated 9/6/07, "Pt. fell unwitnessed on 9/3/07, had no apparent injuries, did not hit head...Began complaining of pain last night, became more agitated with staff while positioning this a.m. will not bear weight on right leg, states Ow, Ow, this afternoon. Called pt. son...he requested she have an x-ray for any fracture at this time. Discussed with assisted living Administrator and pt. sent for x-ray.	{R 008}		

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{R 008}	Continued From page 15 The facility's Progress Notes dated 9/6/07 at 11:00 a.m., documented the following: "On 9/5/07, resident was layed down in bed due to complaining of back pain. Pain has increased and she refused to get up for supper yesterday. Hospice nurse notified..." On 9/6/07, (untimed)..."had increased pain usage times four days, son notified...Would like x-ray done to rule out fracture." Another entry on the facility's Progress Notes on 9/6/07 at 4:15 p.m., "EMT's arrived to transport resident to ER..." 9/6/07 at 6:00 p.m., the hospice nurse Progress Note documented, "Assisted Living Administrator called, pt. has fractured pelvis, no treatment at this time..." Review of the Medical Incident policy (undated) revealed that staff were not directed to notify the facility nurse during an emergency situation or incident, only the adminstrator. Additionally, it stated, "If a transfer to the hospital has taken place, the care staff will contact the resident's physician and responsible party." The policy futher documented, "Care staff will be able, through first aid training and employement orientation done by the administrator, to identify an emergency situation and determine if the situation is minor or major emergency." The policy does not include contacting the facility nurse to assess the resident and determine the appropriate care needed. On 9/18/07 at 3:30 p.m., the administrator confirmed that staff should have called the facility	{R 008}		

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{R 008}	Continued From page 16 nurse after the fall and after increased complaints of pain by the resident. She also verified that staff did not respond appropriately to the emergency situation and stated further training needed to be given for appropriate steps for emergencies. The facility delayed emergency interventions due to lack of training. First, the caregivers assessed the resident after falling, then assisted the resident back to bed without contacting the facility nurse nor emergency services so that the resident could be assessed to determine the needed care. Second, pain medication was given without direction from the facility nurse or hospice nurse; this had the potential to mask signs and symptoms of a serious injury. Third, the resident's son was notified three days after the fall, when the resident's pain and symptoms had increased, and he determined the need for an x-ray. In summary, emergency interventions were delayed by three days because the facility failed to follow the appropriate course of action, because unlicensed staff determined the medical care necessary and did not involve the facility nurse. 2. Resident #6 was admitted on 9/13/06 with diagnoses which included alcoholism, substance abuse and non-Alzheimer's dementia. An incident report dated 8/9/07 at 3:08 p.m., documented the following, "...Resident #6 was found on the floor in a kneeling position...after a quick check helped him set up and took his vitals...took awhile to stand him up and put him onto bed. He was very shaky and weak when we got him on the bed. Took vitals again...called the [house manager] wants me to call [resident's family member], the [family member] said she would call the doctor and call me right back. The	{R 008}		

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{R 008}	Continued From page 17 [family member] called back at 5:55 p.m., and told the staff to call the ambulance and have him transported to the hospital." The facility delayed emergency interventions for resident #6 due to lack of caregiver training. The caregiver did not notify the facility nurse nor emergency services, but instead called the family who directed them on how to deal with the emergency situation. The facility failed to protect resident rights by not providing a safe and sanitary environment based on their cleaning and infection control policies. This had the potential to affect 100% of the residents in the facility. The facility failed to develop NSA's to describe and coordinate Resident #2's hospice cares and services, Resident #4's behavorial needs and Resident #5's oxygen usage. The facility failed to implement Resident #1's NSA regarding the resident's unsteady gait and need for reminders to use his walker correctly. Furthermore, the facility failed to update an NSA for Resident #3 to describe her need for gait belt transfers and the need for two person transfers. Additionally, the facility failed to provide emergency intervention for Resident #3 and Resident #6, as unlicensed caregivers determined the medical care needed not the facility nurse or emergency services. SECOND FAILED FOLLOW-UP SURVEY/REPEAT CORE DEFICIENCY	{R 008}		

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{R 008}	Continued From page 18	{R 008}		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Rosetta Pendlebury	875 S Pendlebury	208-785-3627
Administrator	**City**	**ZIP Code**
Linda Miller	Blackfoot	83221
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	Follow Up #3	9-19-07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	215.09	The administrator did not ensure incident reports were sent to BFS within 24 hours. (repeat)		
2	300.01	The facility nurse did not visit the facility when there was a change in condition: Resident #3 fall with fracture & four random residents.		
3	300.02	The facility nurse did not address changes in residents health or review new orders or treatments prescribed by Physicians: Resident #3 failure to apply ice packs to knee after a fall. Resident #5's to clarify & implement standing orders, per O2 usage.		

Response Required Date	Signature of Facility Representative	Date Signed
10-19-07	Linda J Miller	9/19/07